MONTANA Department of Public Health & Human Services

Eligibility and Enrollment Form

MONTANA BREAST & CERVICAL HEALTH PROGRAM

Eligibility Information

_____ What is your age?

_____ Family's yearly income before taxes?

_____ Number of people in household?

1. Do you have Medicare Part B? ☐ Yes ☐ No
2. Do you have Medicaid? ☐ Yes ☐ No
3. Do you have Health insurance that ***may cover*** these services? ☐ Yes ☐ No

Insurance Company

_____

Enrollment Information

Social Security Number _____-_____-_____ Date of Birth _____/_____/_____
Month Day Year

Name _____ Other Last Name(s) used _____
Last First MI

Mailing Address _____ Street Address _____

City _____ State_____ Zip Code _____ County of Residence _____

Home Phone (_____)_____-_____ Work / Message Phone (_____)_____-_____

Ethnic Background Are you Hispanic? (Spanish/ Hispanic / Latino)

☐ Yes ☐ No ☐ Unknown

Race: Check all races that apply.

- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Unknown

Medical Background

Are you having any breast problems? ☐ Yes ☐ No

Do you have breast implants? ☐ Yes ☐ No

Have you ever had a mammogram? ☐ Yes ☐ No

Date of last mammogram _____/_____
Month Year

Have you ever had a Pap test? ☐ Yes ☐ No

Date of last Pap test _____/_____
Month Year

Have you had a hysterectomy? ☐ Yes ☐ No

How did you hear about the program? Please check all that apply.

☐ Radio ☐ Presentation ☐ Pink/Purple Card (Pamphlet) ☐ Special Promotion/Event/Ad
☐ TV ☐ Medical Provider ☐ Government Office ☐ Newspaper/Newsletter
☐ Internet ☐ MAIWHC ☐ Re-screen/Previously Enrolled ☐ Fair-Job/Health or Pow Wow
☐ Family/Friend/Word of Mouth ☐ _____

PLEASE READ AND SIGN THE BACK OF THIS FORM

Your signature indicates you have read and understand the MBCHP Informed Consent and Authorization to Disclose Health Care Information

Office Use Only Fiscal Yr_____ Site # _____

Form(s) submitted ☐ New Screening Cycle ☐ Re-submitted with revisions

Eligibility determined by (please print)_____ Date_____/_____/_____

Client under age - prior approval given by_____ Date_____/_____/_____

☐ Client under age (18-29) - meets criteria

Please Read and Sign

Informed Consent and Authorization to Disclose Health Care Information

The Montana Breast and Cervical Health program (MBCHP) receives funds from the Centers for Disease Control and Prevention (CDC) to provide breast and cervical cancer screening for age and income eligible Montana women, in order to save lives by detecting cancer and pre-cancerous conditions at the earliest possible time. Each time a woman is screened for breast cancer, CDC recommends she receive a clinical breast exam and a breast X-ray called a mammogram. Each time a woman is screened for cervical cancer, CDC recommends she receive a pelvic examination and Pap test. If any of the initial tests for breast or cervical cancer are abnormal, further diagnostic testing may be required, which may include a diagnostic mammogram, ultrasound, and/or biopsy of the breast or cervical tissue. Because of CDC recommendations, women who enroll in the MBCHP must receive a mammogram, clinical breast exam, Pap test, and pelvic exam. MBCHP will provide case management services that will help you complete all the diagnostic tests and find resources that may help pay for treatment (if necessary). By enrolling in the MBCHP you are accepting responsibility for keeping appointments and completing all the screening and diagnostic tests that are recommended by your medical provider.

Services Not Covered
The MBCHP only provides services for breast and cervical cancer screening and limited diagnostic tests. The program does not cover services for other health conditions, some diagnostic services, or cancer treatment. If I need services that are not covered, the MBCHP staff will refer me to agencies that may help provide treatment. I understand that I may be billed for services not covered by the MBCHP.

Insurance Information
I understand I have met the eligibility guidelines for the MBCHP. I may have insurance coverage and still be eligible to participate. However, my insurance will be billed first for breast and cervical cancer screening services. If the services are not fully reimbursed by my insurance, the MBCHP will pay the unpaid balance up to the maximum allowable Medicare reimbursement rate.

Confidentiality
Any information provided by me will remain confidential, which means that the information will be available only to me, my health care provider, and to the MBCHP staff. The MBCHP staff means those personnel at the Montana Department of Public Health and Human Services, the administrative site and the tribal organizations and Indian Health Service Units who are specifically designated to work in the MBCHP. Program reports will include information on groups of women and will not identify any client by name or tribal affiliation.

Authorization to Disclose Health Care Information
I consent to and authorize the mutual exchange of screening and diagnostic records among the MBCHP staff, my health care provider(s), the laboratory reading my Pap smear, and the radiology facility where my mammogram is performed with respect to MBCHP related services received by me up to six months after the date indicated below. This authorization expires thirty months after the date I signed below.

I have read the information provided herein, discussed this and other information about the MBCHP and agree to participate in the program. I have had an opportunity to ask questions about the MBCHP and have received answers to any questions I had. All information, including financial and insurance benefits, I have provided to the MBCHP is, to the best of my knowledge, true. I understand that my participation is voluntary and that I may drop out of the MBCHP at any time.

Client Signature:	Date:
Print Clients Full Name:	Date:
Witness Signature:	Date: